

<i>SERFF Tracking Number:</i>	<i>MGCC-125666973</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Mega Life and Health Insurance Company - State Tracking Number:</i>		<i>39349</i>
	<i>IC</i>		
<i>Company Tracking Number:</i>	<i>AR 2008 IP RIDERS</i>		
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>2008 AR MEGA CareChoice Riders</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: The Mega Life and Health Insurance Company - IC

Product Name: 2008 AR MEGA CareChoice Riders
 SERFF Tr Num: MGCC-125666973 State: ArkansasLH

TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 39349
Sub-TOI: H21.000 Health - Other	Co Tr Num: AR 2008 IP RIDERS	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Courtney Sharp, Kathleen Allen, Jamie Butler	Disposition Date: 07/02/2008
	Date Submitted: 06/18/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/02/2008	
State Status Changed: 07/02/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

The forms submitted are for your review and approval. These forms are new and not intended to replace any forms previously approved by your Department.

Please note the bracketed items are intended as variable information, and the information enclosed in brackets is our

<i>SERFF Tracking Number:</i>	<i>MGCC-125666973</i>	<i>State:</i>	<i>Arkansas</i>
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	<i>IC</i>		
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<i>Project Name/Number:</i>	<i>/</i>		

standard for your state. At no time will this bracketed information be arranged in such a way to violate the laws of your state.

The forms are to be used in conjunction with previously approved form 26026 PPO-IP AR under SERFF Tracking Number: MGCC-125610406 State Tracking Number: 38722.

To the best of our knowledge, information and belief, the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

The required filing fees,certifications, Actuarial Memorandum and rates are included herewith.

If you have any questions or if anything further is needed to expedite the review of this filing, please call collect at (817) 255-3590. Your assistance in this matter is greatly appreciated.

Kathleen Allen
Senior Compliance Analyst

Company and Contact

Filing Contact Information

Kathleen Allen, Compliance Analyst III	kathleen.allen@healthmarkets.com
9151 Boulevard 26	(817) 255-3590 [Phone]
North Richland Hills, TX 76180	(817) 255-8153[FAX]

Filing Company Information

The Mega Life and Health Insurance Company	CoCode: 97055	State of Domicile: Oklahoma
- IC		
9151 Boulevard 26	Group Code: 264	Company Type: Health
North Richland Hills, TX 76180	Group Name:	State ID Number:
(817) 255-3100 ext. [Phone]	FEIN Number: 59-2213662	

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Company Tracking Number: AR 2008 IP RIDERS
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2008 AR MEGA CareChoice Riders
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Filing Fees

Fee Required? Yes
Fee Amount: \$560.00
Retaliatory? No
Fee Explanation: \$20.00 x 8 forms=\$160.00
\$50.00 x 8 rates=\$400.00
\$160.00 forms + \$400.00=\$560.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Mega Life and Health Insurance Company - IC	\$560.00	06/18/2008	20975510

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Product Name: 2008 AR MEGA CareChoice Riders

Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/02/2008	07/02/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	06/23/2008	06/23/2008	Kathleen Allen	06/25/2008	06/25/2008

State: *Arkansas*

Filing Company: The Mega Life and Health Insurance Company - State Tracking Number: 39349
IC

Company Tracking Number: AR 2008 IP RIDERS

TOI: *H21 Health - Other*

Sub-TOI: *H21.000 Health - Other*

Product Name: 2008 AR MEGA CareChoice Riders

Project Name/Number: _____ / _____

Disposition

Disposition Date: 07/02/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MGCC-125666973 State: Arkansas

Filing Company: The Mega Life and Health Insurance Company - State Tracking Number: 39349

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Company Tracking Number: AR 2008 IP RIDERS

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: 2008 AR MEGA CareChoice Riders

Project Name/Number: /

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Return of Premium Rider	Approved-Closed	Yes
Form	Continued Care Benefit Rider	Approved-Closed	Yes
Form	Air Ambulance Rider	Approved-Closed	Yes
Form	Pregnancy/Childbirth Benefit Rider	Approved-Closed	Yes
Form	Legend Prescription Drug Expense Rider	Approved-Closed	Yes
Form	Outpatient Accident Expense Benefit Rider	Approved-Closed	Yes
Form	[Preventive Plus] Benefit Rider	Approved-Closed	Yes
Form	Outpatient Speech Therapy, Physical Therapy & Occupational Therapy Rider	Approved-Closed	Yes

SERFF Tracking Number: MGCC-125666973 State: Arkansas
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Product Name: 2008 AR MEGA CareChoice Riders
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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/23/2008
Submitted Date 06/23/2008
Respond By Date
Dear Kathleen Allen,
This will acknowledge receipt of the captioned filing.

Objection 1

- Legend Prescription Drug Expense Rider (Form)

Comment: Your attention is called to the 90-day supply for mail service legend prescription drugs.

ACA 23-79-149 (d) states that..."Insurance policies shall not set a limit on the quantity of drugs which an enrollee may obtain at any one time with a prescription, unless the limit is applied uniformly to all pharmacy providers in the insurance policy's network. ...". If the mail service is a network provider, the 90-day supply is not in compliance with the above statute.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/25/2008
Submitted Date 06/25/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: The designated mail service pharmacy is not a part of our retail participating pharmacy network, but rather mail service prescription drugs are dispensed directly through our PBM (Prescription Benefit Manager). This mail service is very beneficial to insureds that are on maintenance prescription drugs who, under the mail service benefit,

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Product Name: 2008 AR MEGA CareChoice Riders
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would be able to receive a 3 month supply of the drug at a less copay vs. the 30 day supply limit under a retail pharmacy.

Related Objection 1

Applies To:

- Legend Prescription Drug Expense Rider (Form)

Comment:

Your attention is called to the 90-day supply for mail service legend prescription drugs.

ACA 23-79-149 (d) states that...."Insurance policies shall not set a limit on the quantity of drugs which an enrollee may obtain at any one time with a prescription, unless the limit is applied uniformly to all pharmacy providers in the insurance policy's network. ...". If the mail service is a network provider, the 90-day supply is not in compliance with the above statute.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,

Courtney Sharp, Jamie Butler, Kathleen Allen

SERFF Tracking Number: MGCC-125666973 State: Arkansas

Filing Company: The Mega Life and Health Insurance Company - State Tracking Number: 39349

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Company Tracking Number: AR 2008 IP RIDERS

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: 2008 AR MEGA CareChoice Riders

Project Name/Number: /

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	25044-IR	Policy/Cont Return of Premium ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			25044 IR.pdf
Approved-Closed	25883 (10/05)-IR AR	Policy/Cont Continued Care ract/Fratern Benefit Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			25883 _1005_-IR AR.pdf
Approved-Closed	25983 (10/05)-IR	Policy/Cont Air Ambulance Rider ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			25983-IR.pdf
Approved-Closed	25984 (10/05)-IR AR	Policy/Cont Pregnancy/Childbirth ract/Fratern Benefit Rider al Certificate:	Initial			25984 _1005_-IR AR.pdf

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<i>Project Name/Number:</i>	<i>/</i>		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- 25985	Policy/Cont Legend Prescription Initial		25985
Closed (10/05)-IR	ract/Fratern Drug Expense Rider		_1005_-IR
AR	al		AR.pdf
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- 25987	Policy/Cont Outpatient Accident Initial		25987-IR.pdf
Closed (10/05)-IR	ract/Fratern Expense Benefit		
	al Rider		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- 26028	Policy/Cont [Preventive Plus] Initial		26028
Closed (10/05)-IR	ract/Fratern Benefit Rider		_1005_-IR.pdf
	al		
	Certificate:		
	Amendmen		
	t, Insert		
	Page,		
	Endorseme		
	nt or Rider		
Approved- 26029	Policy/Cont Outpatient Speech Initial		26029
Closed (10/05)-IR	ract/Fratern Therapy, Physical		_1005_-IR.pdf
	al Therapy &		
	Certificate: Occupational		
	Amendmen Therapy Rider		

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	IC		
Company Tracking Number:	AR 2008 IP RIDERS		
TOI:	H21 Health - Other	Sub-TOI:	H21.000 Health - Other
Product Name:	2008 AR MEGA CareChoice Riders		
Project Name/Number:	/		
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	nt or Rider		

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

ENDORSEMENT RETURN OF PREMIUM BENEFIT

DEFINITIONS

“Premiums Paid” – All premiums You have paid for insurance under the Policy (and any attached riders) for You and Your Covered Dependents beginning with the Effective Date of this benefit.

“Pro-Rata Factor” – An amount equal to the number of complete years measured from the Effective Date of this benefit to the date the Policy is terminated divided by the number of complete years measured from the Effective Date of this benefit to the date You would reach 65.

BENEFITS

If this benefit is continuously in force from its Effective Date until the date You reach 65, We will pay You an amount equal to the Premiums Paid less any claims We paid under the Policy for You and Your Covered Dependents.

If, after Your coverage under this benefit has been in force for at least five (5) years, We terminate the Policy without providing similar coverage under another policy, a ProRata amount will be paid. This amount will equal the Premiums paid, less any claims paid for You and Your Covered Dependents, multiplied by the Pro-Rata Factor.

If, after Your coverage under this benefit has been in force for at least five (5) years coverage under the Policy for You and Your Covered Dependents terminates due to death; lapse or surrender of Your Policy , We will pay the Surrender Value. The Surrender Value is equal to

- The sum of : The total premiums for Your Policy and all attached riders'
- Times: The applicable percentage shown in the Table of Surrender Value Percentages,
- Less: The total of all benefits paid under Your Policy.

No Surrender Value accrues before the end of the fifth Policy year. You must surrender the Policy in its entirety before payment of the Surrender Value. This means the Policy will terminate on the date that the Surrender Value is calculated and paid. Surrender of the Policy automatically terminates Your right to any further benefits.

Table of Surrender Value Percentages (Issue Ages 18-34)

End of Policy Year	YOUR ISSUE AGE																	End of Policy Year
	18 0%	19 0%	20 0%	21 0%	22 0%	23 0%	24 0%	25 0%	26 0%	27 0%	28 0%	29 0%	30 0%	31 0%	32 0%	33 0%	34 0%	
1-5																		1-5
6	5	5	5	5	5	6	6	6	6	6	7	7	7	7	8	8	8	6
7	8	8	9	9	9	9	10	10	11	11	11	12	12	13	13	14	14	7
8	11	11	11	12	12	13	13	14	14	15	15	16	16	17	18	18	19	8
9	13	13	14	14	15	15	16	16	17	18	18	19	20	20	21	22	23	9
10	15	15	16	16	17	18	18	19	20	20	21	22	23	24	25	26	27	10
11	16	17	17	18	19	19	19	21	22	23	24	24	25	26	28	29	30	11
12	18	18	19	20	21	22	22	23	24	25	26	27	28	29	30	32	33	12
13	19	20	21	21	22	23	24	25	26	27	28	29	30	32	33	34	36	13
14	21	21	22	23	24	25	26	27	28	29	30	31	33	34	35	37	38	14
15	22	23	24	25	25	26	27	29	30	31	32	33	35	36	38	39	41	15
16	23	24	25	26	27	28	29	30	32	33	34	35	37	39	40	42	44	16
17	25	25	26	27	29	30	31	32	33	35	36	38	39	41	43	44	46	17
18	26	27	28	29	30	31	32	34	35	37	38	40	41	43	45	47	49	18
19	27	28	29	30	32	33	34	35	37	38	40	42	43	45	47	50	52	19
20	28	29	31	32	33	34	36	37	39	40	42	44	46	48	50	52	55	20
21	30	31	32	33	35	36	37	39	41	42	44	46	48	50	53	55	58	21
22	31	32	33	35	36	38	39	41	43	44	46	48	50	53	55	58	61	22
23	32	34	35	36	38	39	41	43	45	46	49	51	53	55	58	61	64	23
24	34	35	36	38	40	41	43	45	47	49	51	53	56	58	61	64	67	24
25	35	37	38	40	41	43	45	47	49	51	53	56	58	61	64	67	71	25
26	37	38	40	41	43	45	47	49	51	53	56	58	61	64	68	71	75	26
27	38	40	41	43	45	47	49	51	53	56	59	61	64	68	71	75	79	27
28	40	41	43	45	47	49	51	53	56	59	61	64	68	71	75	79	84	28
29	41	43	45	47	49	51	54	56	59	61	65	68	71	75	79	87	89	29
30	43	45	47	49	51	54	56	59	61	65	68	71	75	79	84	89	94	30
31	45	47	49	51	54	56	59	61	65	68	71	75	79	84	89	94	100	31
32	47	49	51	54	56	59	61	65	68	71	75	79	84	89	94	100		32
33	49	51	54	56	59	61	65	68	71	75	79	84	89	94	100			33
34	51	53	56	59	61	65	68	71	75	79	84	89	94	100				34
35	53	56	59	61	64	68	71	75	79	84	89	94	100					35
36	56	59	61	64	68	71	75	79	84	89	94	100						36
37	59	61	64	68	71	75	79	84	89	94	100							37
38	61	64	68	71	75	79	84	89	94	100								38
39	64	68	71	75	79	84	89	94	100									39
40	68	71	75	79	84	89	94	100										40
41	71	75	79	84	89	94	100											41
42	75	79	84	89	94	100												42
43	79	84	89	94	100													43
44	84	89	94	100														44
45	89	94	100															45
46	94	100																46
47	100																	47
At Age 65	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	At Age 65

Table of Surrender Value Percentages (Issue Ages 35-50)

End of Policy Year	YOUR ISSUE AGE																End of Policy Year
	35 0%	36 0%	37 0%	38 0%	39 0%	40 0%	41 0%	42 0%	43 0%	44 0%	45 0%	46 0%	47 0%	48 0%	49 0%	50 0%	
1-5																	1-5
6	9	9	9	10	10	11	11	12	12	13	13	14	15	16	17	18	6
7	15	16	16	17	18	18	19	20	21	22	23	25	26	28	29	31	7
8	20	21	22	23	24	25	26	27	28	30	31	33	35	37	40	42	8
9	24	25	26	27	29	30	31	33	34	36	38	40	43	45	49	52	9
10	28	29	30	32	33	35	36	38	40	42	44	47	50	53	57	61	10
11	31	33	34	35	37	39	41	43	45	47	50	53	56	60	64	69	11
12	34	36	37	39	41	43	45	47	50	52	55	59	62	67	71	77	12
13	37	39	41	43	45	47	49	52	54	57	61	64	68	73	78	84	13
14	40	42	44	46	48	50	53	56	59	62	66	70	74	80	85	92	14
15	43	45	47	49	52	54	57	60	63	67	71	75	80	86	93	100	15
16	46	48	50	52	55	58	61	64	68	72	76	81	87	93	100		16
17	48	51	53	56	59	62	65	69	73	77	82	87	93	100			17
18	51	54	56	59	62	66	69	73	77	82	88	94	100				18
19	54	57	60	63	66	70	74	78	83	88	94	100					19
20	57	60	63	66	70	74	78	83	88	94	100						20
21	60	63	67	70	74	78	83	88	94	100							21
22	64	67	71	74	79	83	88	94	100								22
23	67	71	75	79	83	88	94	100									23
24	71	75	79	84	89	94	100										24
25	75	79	84	89	94	100											25
26	79	84	89	94	100												26
27	84	89	94	100													27
28	89	94	100														28
29	94	100															29
30	100																30
At Age 65	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	At Age 65

This benefit is made a part of the Policy to which it is attached. It is subject to all provisions, terms, definitions, and limitations of the Policy which are not in conflict with the provisions of this benefit.

We will provide this benefit in consideration of the payment of the additional premium for it.

Benefit Effective Date, if different from Policy Date: _____

The MEGA Life and Health Insurance Company at North Richland Hills, Texas



SECRETARY

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma

Administrative Office: P.O. Box 982010

North Richland Hills, Texas 76182-8010

Customer Service: 1-800-527-5504

CONTINUED CARE BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Policy which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Policy and any other rider and are subject to the Maximum Benefits, Coinsurance and other limitations shown for this Rider [and the Policy Deductible shown] in the POLICY SCHEDULE.

[Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

COVERED EXPENSES

Benefits are payable under this Rider immediately following a covered Hospital Confinement for Medically Necessary continued care in accordance with a Treatment Plan.

Skilled Nursing Care

Covered Expenses include charges incurred during Confinement in a Skilled Nursing Facility in accordance with a Treatment Plan which begins within 14 days following a Hospital Confinement for the same Injury or Sickness.

Skilled Nursing Facility means a facility which:

1. is licensed by the State;
2. provides skilled nursing care under the supervision of a Physician;
3. has 24 hour-a-day nursing services by or under the supervision of a registered graduate professional nurse (R.N.);
4. keeps a daily medical record of each patient; and
5. provides full-time bed care for resident patients.

It does not include a facility or any of its sections which is a place for persons suffering from a Mental or Nervous Disorder, alcohol or drug problems, or which is used mainly as a home for rest or for the aged. Nor does the term include an institution which is operated mainly for domiciliary or custodial care or as a school for the education of patients.

Home Health Care

Covered Expenses include services or supplies furnished by a Home Health Care Agency in accordance with a Treatment Plan which begins within 7 days following a Skilled Nursing Facility stay or Hospital Confinement for the same Injury or Sickness.

Home Health Care Agency means a public or private agency or organization licensed in the state in which it is located, to provide home health care services.

Private Duty Nurse

Covered Expenses include the services of a Private Duty Nurse in accordance with a Treatment Plan which begins within 7 days following a Skilled Nursing Facility stay or Hospital Confinement for the same Injury or Sickness.

Private Duty Nurse means a registered graduate professional nurse (R.N.), licensed vocational nurse (L.V.N), licensed practical nurse (L.P.N.) or any other legally licensed or certified nursing professional who provides care within the scope of his or her license or certificate. (A member of the Insured Person's Immediate Family will not be considered a Private Duty Nurse.)

Hospice Care

Covered Expenses include services and supplies provided by a Hospice in accordance with a Treatment Plan if:

1. the Insured Person's Physician certifies that the Insured Person has a life expectancy of not more than 6 months; and
2. such care is provided to reduce or abate pain and not for cure.

Hospice means an agency which provides limited periods of care for terminally ill persons and is licensed, certified or registered in accordance with state law.

Treatment Plan means a written plan by the Insured Person's Physician which indicates but is not limited to:

1. the condition requiring treatment, along with recommended procedures and a certification that without such care the Insured Person would be Hospital Confined;
2. the anticipated date of Confinement or schedule of services and supplies; and
3. the facility to be used, if any.

We reserve the right to request an updated Treatment Plan to substantiate the necessity of continued care.


We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Policy Date: _____

The MEGA Life and Health Insurance Company at North Richland Hills, Texas



SECRETARY



PRESIDENT

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

AIR AMBULANCE RIDER

This Rider is made a part of the Policy to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Policy which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Policy and any other rider and are subject to the [maximum benefit amount,] [Copayment] [and Coinsurance] shown for this Rider in the POLICY SCHEDULE.

[Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

BENEFITS

We will pay benefits while this Rider is in force for Air Ambulance transportation to the nearest available medical facility that can provide adequate care in the event of a Medical Emergency, as defined in the Policy.

This benefit is payable only if:

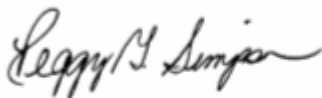
1. the Insured Person requires an advanced level of care during transportation; [and]
2. the potential delays which may be associated with ground transportation, including road conditions and traffic, could jeopardize the Insured Person's condition[.]; and
3. the Insured Person is Hospital Confined.]

Air Ambulance means a privately or publicly owned aircraft appropriately licensed by the state where the service originated, that is designed and used to provide air transport of persons suffering from a Sickness or Injury and that contains all life-saving equipment and staff as required by state and local law.

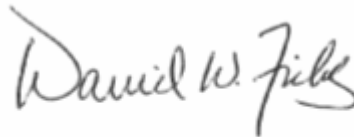
We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Policy Date: _____

The MEGA Life and Health Insurance Company at North Richland Hills, Texas



SECRETARY



PRESIDENT

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma

Administrative Office: P.O. Box 982010

North Richland Hills, Texas 76182-8010

Customer Service: 1-800-527-5504

PREGNANCY/CHILDBIRTH BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. The Rider is subject to the all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Policy which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Policy and any other rider and are subject to the Maximum Benefit amount [Copayment] [and Coinsurance] shown for this Rider in the POLICY SCHEDULE.

[Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

COVERED EXPENSES

We will pay benefits for Covered Expenses incurred as a result of in vitro fertilization procedures and/or normal pregnancy/childbirth as follows:

Coinsurance	
[0-10] months in force	[0%]
[11-24] months in force	[50%] of Covered Expenses not to exceed a [\$2,000] Maximum Benefit per in vitro fertilization procedure and/or pregnancy/childbirth for You or Your Covered Dependent Spouse
[25] months in force and over	[100%] of Covered Expenses not to exceed a [\$2,000] Maximum Benefit per in vitro fertilization procedure and/or pregnancy/childbirth for You or Your Covered Dependent Spouse

In vitro fertilization benefits will be limited to a Lifetime Maximum of [\$15,000].

If childbirth should occur prematurely, benefits payable will be those benefits, if any, which would have been payable if childbirth had occurred at full term. We will require a Physician to furnish medical evidence confirming the inception date of such pregnancy.

In Vitro Fertilization

Covered Expenses incurred for expenses arising from in vitro fertilization procedures performed on the Insured Person or Insured Person's Covered Dependent spouse if the following requirements are met:

1. the Insured Person or Insured Person's Covered Dependent spouse's oocytes are fertilized with the sperm of the Insured Person or Insured Person's Covered Dependent spouse;
2. the Insured Person and the Insured Person's Covered Dependent spouse have a history of unexplained infertility of at least two (2) years' duration or the infertility is associated with one or more of the following conditions:
 - a. endometriosis;
 - b. exposure in utero to diethylstilbestrol (DES);
 - c. blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
 - d. abnormal male factors contributing to the infertility; and

3. the in vitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization.
4. the Insured Person or Insured Person's Covered Depended spouse has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under this contract.

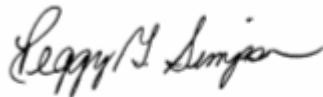
Cryopreservation, the procedure whereby embryos are frozen for later implantation, will be included as an in vitro fertilization procedure.

Complications of Pregnancy, as defined in the Policy, are payable under the Policy and are subject to the Policy Deductible, if any, and all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Policy.


We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Policy Date: _____

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LEGEND PRESCRIPTION DRUG EXPENSE RIDER

This Rider is made a part of the Policy to which it is attached. The Rider is subject to all provisions, terms and DEFINITIONS of the Policy which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Policy and any other rider and are subject to the Benefit Payment Rate/Deductible/Copayment and Benefit Maximum stated herein.

BENEFITS

If an Insured Person incurs Covered Expenses for Sickness or Injury, We will pay a benefit. This benefit is the amount equal to the actual charge based on Participating Pharmacy prices for a Covered Expense, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

[We have adopted a list of formulary medications that meet quality, safety and efficacy standards and are more cost effective to the Plan. You may call Us if You wish to obtain a copy of the formulary list. All drugs which do not appear on Our formulary list are referred to as "non-formulary drugs." Non-formulary drugs require a higher cost sharing amount on Your part.] You have the option to receive drugs either retail or through Our Mail Service Legend Prescription Drug Program.

BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT

BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT

A Deductible of [\$50] [\$100] [\$150] [\$200] [\$250] will apply each Calendar Year to each Insured Person. After the Deductible is met, We will pay benefits subject to the applicable Benefit Payment Rate and/or Copayment specified below.

Participating Pharmacy

Generic Drugs (not to exceed a 30 day supply)

We pay [100%] less the [\$15] Copayment

Formulary Drugs (not to exceed a 30 day supply)

We pay [50%], you pay the remainder

Non-Formulary Drugs (not to exceed a 30 day supply)

We pay [25%] [50%], you pay the remainder

Non-Participating Pharmacy

Generic Drugs (not to exceed a 30 day supply)

We pay [75%] less the [\$15] Copayment

Formulary Drugs (not to exceed a 30 day supply)

We pay [25%], you pay the remainder

Non-Formulary Drugs (not to exceed a 30 day supply)

We pay [0%], you pay the remainder

Mail Service Legend Prescription Drugs

(Not to exceed a 90 day supply through Our designated mail service program)

Generic Drugs

We pay [100%] less the [\$30] Copayment

Formulary Drugs

We pay [50%], you pay the remainder

Non-Formulary Drugs

We pay [25%], you pay the remainder

Benefit Maximum

Per Insured Person

[\$1,000] [\$1,500] [\$2,000] [\$2,500] per Calendar Year]

LEGEND PRESCRIPTION DRUGS FROM A PARTICIPATING/NON-PARTICIPATING PHARMACY OR MAIL ORDER VENDOR:

1. When You have a prescription filled, You must pay the appropriate Copayment/Benefit Payment Rate set forth above, if any, for each separate prescription or refill for each drug. The Participating Pharmacy/Mail Order Vendor will be paid directly by Us for the remainder of the cost of the prescription or refill, subject to the Benefit Payment Rate/Deductible/Copayment set forth above.
2. If generic drugs are obtained through a Non-Participating Pharmacy, You must pay the Pharmacy for each prescription or refill for that generic drug and submit a claim to ["Caremark, P.O. Box 853901, Richardson, Texas 75085"], for reimbursement. Benefits payable are subject to the Deductible, Non Participating Pharmacy Benefit Payment Rate amount set forth above. Any benefits payable for prescriptions filled by a Non-Participating Pharmacy may not exceed those benefits payable for the same prescription filled by a Participating Pharmacy, where available.
3. If You have a prescription filled with a brand name drug, and there is a therapeutic generic equivalent drug for that brand drug, We have special payment rules regarding reimbursement when a therapeutic generic equivalent drug could have been prescribed. We have created a list of generic drugs that the FDA has categorized as therapeutic equivalents to the corresponding brand name drug.

Our payment will be based on the therapeutic generic equivalent drug fee schedule, which We have created for these therapeutic generic equivalent drugs or the actual drug charge, whichever is less. **You will be responsible for the generic drug Copayment set forth above and the difference in cost between Our payment and the actual cost of the brand name drug.**

For example, assume You have a prescription for a brand name drug that costs \$100, and the therapeutic equivalent generic has a fee schedule of \$25. We will pay the \$25, less the applicable Copayment amount (\$[10.00] [\$15.00]). **You must pay the generic drug Copayment amount plus the \$75 balance remaining on the \$100 charge.**

DEFINITIONS

Copayment means the amount which may be charged to the Insured Person by the Pharmacy for the dispensing, including each refill, of any Legend Prescription Drug, before We will make any payments under this Rider.

Deductible means the amount of Covered Expenses that an Insured Person must pay each [Calendar Year] before benefits will be paid. The Deductible does not include non-Covered Expenses.

Covered Expense means the actual charges for:

1. Legend Prescription Drugs.
2. Compounded medication of which at least one ingredient is a Legend Prescription Drug.
3. Any other drug which, under the applicable state law, may be only dispensed upon written prescription of a Physician or other lawful prescriber.

Legend Prescription Drugs mean drugs, devices, biological and compounded prescriptions which can be dispensed only pursuant to a prescription; which by law are required to bear the legend "Caution – Federal Law prohibits dispensing without a prescription." The drug or device must be prescribed by an Insured Person's Physician or other licensed/authorized health care provider, and approved by the FDA for the treatment of the Insured Person's specific diagnosis or condition, or with regard to drugs for the treatment of cancer: (1) recognized as safe and effective for the treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one or more of such compendia: (a) the American Hospital Formulary Service drug information; (b) the United States Pharmacopoeia dispensing information; or (2) the drug has been recognized as safe and effective for the treatment of that specific type of cancer in two articles from the medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.

In certain situations, specific criteria including Medical Necessity criteria, may be established by Us and Our provider community, which defines whether certain drugs will be covered under this Rider.

We reserve the right to require prior authorization for any drug prior to payment under this Rider. You may call Us if You wish to obtain a list of drugs which require prior authorization.

Non-Participating Pharmacy means any retail Pharmacy which regularly dispenses Legend Prescription Drugs and has not entered into a Participation Agreement with Us.

Participating Pharmacy means any retail Pharmacy which regularly dispenses Legend Prescription Drugs and has entered into a Participation Agreement with Us.

Pharmacy means a facility where the practice of Pharmacy occurs.

Prescription Order means the request for a drug or device issued by a Physician or other qualified provider duly licensed to make such a request in the ordinary course of his/her professional practice.

EXCLUSIONS

We will not provide any benefits for:

1. Expenses incurred after coverage terminates under this Rider;
2. Non-legend drugs;
3. Insulin, insulin syringes, needles and other diabetic supplies;
4. Devices of any type, even though such devices may require a Prescription Order, such as, but not limited to, therapeutic devices, artificial appliances, hypodermic needles, syringes, support garments, ostomy supplies, and other non-medical substances, or similar devices, regardless of intended use;
5. Immunization agents, allergy sera, biological sera, blood or blood products administered on an outpatient basis;
6. Anti-smoking aids (e.g. Nicorette gum, nicotine patches);
7. Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental drugs, even though a charge is made to the Insured Person;
8. Products used for unapproved cosmetic indications;
9. Any illegal substance;
10. Drugs used to treat or cure baldness, and anabolic steroids used for body building;
11. Any charge for the administration of Legend Prescription Drugs or injectable insulin;
12. Drugs for participants covered under Medicare or Medicaid programs, or drugs paid by or covered under any benefit or insurance program;
13. Non-injectable vitamins or fluorides or health foods, health and beauty aids, cosmetics, nutritional or dietary supplements;
14. Drugs determined to be "less than effective" by the Drug Efficacy Study Implementation (DESI) Program. For example: Equagesic, Midrin, Cyclospasmol, and Vasodilan have been rated less-than-effective. The Omnibus Budget Reconciliation Act of 1981 has mandated the Health Care Financing Administration to ban reimbursement for less-than-effective drugs products by federal Medicare/Medicaid agencies;
15. Any medication, legend or not, which is consumed or administered at the place where it is dispensed;
16. Anorectic, Weight control drugs; or
17. Fertility drugs.
18. All injectables (except emergency allergic reaction kits) plus the administration, unless required by law;
19. Sexual function, dysfunction, inadequacy or desire including but not limited to erectile dysfunction drugs;
20. Non-Generic psychotherapeutic agents, including but not limited to those prescribed for the treatment of anxiety, psychosis or depression; or][Psychotherapeutic agents, including but not limited to those prescribed for the treatment of a Mental or Nervous Disorder [except as otherwise noted];or]
21. Growth hormones;
22. Amphetamines;
23. Sleeping aids (sedative/hypnotic);
24. Attention Deficit Disorder (ADD)/Attention Hyperactivity Disorder (ADHD) medications (includes those drugs that have labeled indications for this medical condition;
25. The costs of compounding Federal Legend Prescription Drugs with non-Federal Legend Prescription Drug ingredients;

26. [Legend Prescription Drugs prescribed for “quality of life” or “lifestyle” concerns including but not limited to smoking cessation; obesity; hair loss; sexual function, dysfunction, inadequacy or desire; or cognitive enhancement.]

LIMITATIONS

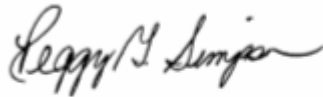
The following dispensing limits will apply to each prescription:

1. **Participating/Non-Participating Pharmacy** – No more than a [30 day] supply or [100 unit doses], whichever is less, may be dispensed. No more than two refills of the same prescription may be dispensed in any one Calendar Year. For certain drugs, less than a [30 day] supply or [100 unit doses] may be dispensed.
2. **Mail Service Legend Prescription Drugs** – No more than a [90 day] supply may be dispensed at any one time. For certain drugs, less than a [90 day] supply may be dispensed.

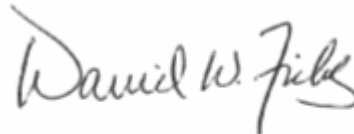
We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Policy Date: _____

The MEGA Life and Health Insurance Company at North Richland Hills, Texas



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Customer Service: 1-800-527-5504

OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Policy which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Policy and any other rider and are subject to the [Rider deductible and the maximum benefit amount] shown for this Rider in the POLICY SCHEDULE.

[Benefits paid under this Rider and amounts used to satisfy the Rider deductible will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

COVERED EXPENSES

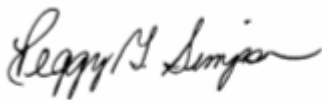
We will pay benefits for Covered Expenses of an Insured Person while this Rider is in force, for the Medically Necessary treatment of an Injury while not Hospital Confined. This benefit will be payable subject to the following conditions:

1. Initial treatment by a Physician must begin within 72 hours of the Injury; and
2. Any treatment of the Injury, beyond the initial treatment, must be received within 45 days of the Injury.

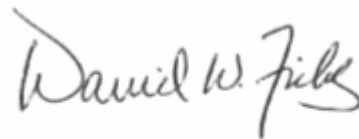
We will provide this benefit in consideration of the payment of the required premium for this Rider.

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[PREVENTIVE PLUS] BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. The Rider is subject to the all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Policy which are not inconsistent with the provisions of this Rider.

This Rider provides benefits for the following [Medically Necessary] [non-Covered Expenses]:

[Physician office visits, except for visits related to Mental or Nervous Disorders or fertility treatment;]
[Allergy injections;]
[Outpatient Diagnostic expenses not otherwise considered a Covered Expense under the Policy or any attached Riders;]
[Emergency Room services not otherwise considered a Covered Expense under the Policy or any attached Riders; and]
[Spinal manipulations]

[The following preventive services will also be considered under this Rider:]

[Routine preventive health care services, including but not limited to routine physical exams and related laboratory and x-rays services and immunizations, not otherwise paid under the Policy; and]
[Acupuncture]

All benefits under this Rider are subject to [Usual and Customary Charges][the Maximum Allowable Charge (MAC)]. The amount payable under this Rider is based on the Quarterly Benefit Accumulation Amount and subject to the Benefit Accumulation provision shown below:

ANNUAL [PREVENTIVE PLUS] BENEFIT

AMOUNT SELECTED: [\$250][\$500][\$1,000][\$2000]

QUARTERLY BENEFIT ACCUMULATION AMOUNT: [\$62.50][\$125][\$250][\$500] per quarterly Rider anniversary for You and Your Covered Dependents, if any

The services payable under this Rider are not subject to any Coinsurance [or, Copayment] [and Deductible] requirements and will not count toward or be used to satisfy the Policy Deductible, Coinsurance or Copayments, if any.

Any Pre-Existing Condition limitations, conditions excluded by Waiver or Benefits paid under the Policy or any attached Riders, will not be considered under this Rider.

BENEFIT ACCUMULATION

Benefits under this Rider can accumulate if unused. Any portion of the [PREVENTIVE PLUS] Benefit Amount not used by the end of the quarterly Rider anniversary may be carried forward and used in the next quarter. Additionally, at the end of the each annual Rider anniversary, an amount equal to [10%] of unused benefits will be added to the [PREVENTIVE PLUS] Benefit Amount.

At no time can the benefit available to You under this Rider accumulate to more than [\$1,000][\$2,000][\$4,000] or [\$2,000][\$4,000][\$8,000] for You and Your Covered Dependents. If more than one Insured Person is covered under this Rider, the maximum benefit amount available to each Insured Person may not exceed [\$350][\$700][\$1,050] for each full year the Policy is in force.

Example 1: If You and Your Covered Dependents have a \$125 quarterly [PREVENTIVE PLUS] Benefit Amount and Your Rider Effective Date is January 1st, on January 1st, a \$125 [PREVENTIVE PLUS] Benefit Amount is available to You and Your Covered Dependents. If during the 1st quarter Your Rider is in force, \$100 of the [PREVENTIVE PLUS] Benefit Amount is used, on April 1st, the [PREVENTIVE PLUS] Benefit Amount will be \$150 (the new Rider anniversary quarter \$125 [PREVENTIVE PLUS] Benefit Amount plus the unused \$25 from the prior quarter).

Example 2: If You and Your Covered Dependents have a \$125 quarterly [PREVENTIVE PLUS] Benefit Amount, Your Rider Effective Date is May 1st and during the first year coverage is in force under this Rider, \$0 of the [PREVENTIVE PLUS] Benefit Amount is used, on May 1st of the following year, the [PREVENTIVE PLUS] Benefit Amount will be \$675 (four quarters of unused [PREVENTIVE PLUS] Benefit Amounts ($\$125 \times 4 = \500) plus the end of Rider year 10% ($10\% \times \$500 = \50) plus the new Rider quarter's [PREVENTIVE PLUS] Benefit Amount (\$125)).

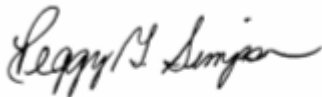
Benefits will be paid from the [PREVENTIVE PLUS] Benefit Amount on the date the services are rendered. Benefits accumulated subsequent to the date the services are rendered will not be used to pay benefits on services rendered before the accumulation date.

In order for benefits to be considered under this Rider, services must be rendered during the time period for which premium has been paid for this Rider.

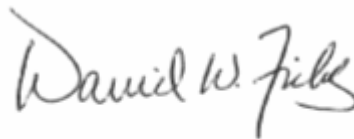
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OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY RIDER

This Rider is made a part of the Policy to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Policy which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit amount,] [Copayment,] [Coinsurance] and any other limitation shown for this Rider in the POLICY SCHEDULE.

[Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

COVERED EXPENSES

We will pay benefits for Covered Expenses incurred for Speech Therapy, Physical Therapy and Occupational Therapy that is related to and necessary for the treatment of a Sickness or Injury. In order to be considered a Covered Expense, therapy services must commence within 14 days of a covered Hospital Confinement or Surgery and be rendered in the 90 days immediately following the related covered Hospital Confinement or Surgery. Therapy provided beyond 90 days following a Hospital Confinement or Surgery will not be considered a Covered Expense.

For the purpose of this Rider:

Occupational Therapy means the use of purposeful activities to restore and maximize independence, prevent associated disability, and maintain health. The practice encompasses assessment, treatment and consultation for individuals and groups in healthcare, educational, and community settings.

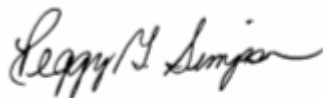
Physical Therapy means physical or corrective rehabilitation or physical or corrective treatment of any bodily or mental condition of any person by the use of physical, chemical, and other properties of heat, light, water, electricity, sound, and active, passive, and resistive exercise, and shall include evaluation, treatment planning, instruction and consultative services. Physical Therapy does not include spinal manipulations or manipulative therapy.

Speech Therapy means the application of principles, methods, and procedures for measurement, testing, identification, prediction, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of identifying, preventing, managing, habilitating, or rehabilitating, ameliorating, or modifying such disorders and conditions in individuals or groups of individuals.

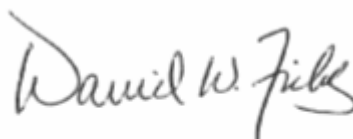
Rider effective date, if different from Policy Date: _____

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The MEGA Life and Health Insurance Company at North Richland Hills, Texas



SECRETARY



PRESIDENT

State: *Arkansas*

Filing Company: The Mega Life and Health Insurance Company - State Tracking Number: 39349
IC

Company Tracking Number: AR 2008 IP RIDERS

TOI: H21 Health - Other

Sub-TOI: *H21.000 Health - Other*

Product Name: 2008 AR MEGA CareChoice Riders

Project Name/Number: _____ / _____

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MGCC-125666973 State: Arkansas
Filing Company: The Mega Life and Health Insurance Company - State Tracking Number: 39349
IC
Company Tracking Number: AR 2008 IP RIDERS
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: 2008 AR MEGA CareChoice Riders
Project Name/Number: /

Supporting Document Schedules

Satisfied -Name: Certification/Notice	Review Status: Approved-Closed	07/02/2008
Comments: Please refer to attached.		
Attachments: ARGA 0104.pdf Cert Compl Rule-Reg19 -AR.pdf Cert Compliance AR-Readability.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	07/02/2008
Comments: Form number: 25098-APP (2/08) Approval date: 12/18/07		
Satisfied -Name: Outline of Coverage	Review Status: Approved-Closed	07/02/2008
Comments: Please refer to the attached outlines of coverage which reference the riders that have been previously approved under SERFF Tracking Number: MGCC-125610406; State Tracking Number: 38722		
Attachments: 26026 IP OC AR.pdf 26026 IP OC AR NOTICE.pdf		

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract..

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice.

**The Arkansas Life and Health Insurance Guaranty Association
C/O The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201**

**Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904**

The state law that provides for this safety-net coverage is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and they hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies or contracts are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;

- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans, to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of any unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits for net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.]

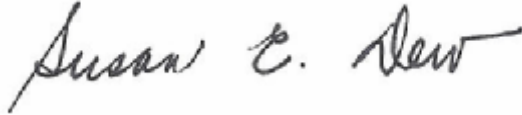
**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: The MEGA Life and Health Insurance Company

Form Number(s):

25044-IR; 25883 (10/05)-IR AR; 25983 (10/05)-IR; 25984 (10/05)-IR AR; 25985 (10/05)-IR AR; 25987 (10/05)-IR; 26028 (10/05)-IR; 26029 (10/05)-IR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Susan Dew

Name

Vice President and Chief Compliance Officer

Title

June 18, 2008

Date

Certificate of Compliance for Arkansas

This is to certify the attached form has achieved the Flesch Reading Ease Score given below and complies with the requirements of Arkansas Stat. Ann, 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language simplification Act.

Form Numbers and Form Names:

25044-IR	Return of Premium Rider
25883 (10/05)-IR AR	Continued Care Benefit Rider
25983 (10/05)-IR	Air Ambulance Rider
25984 (10/05)-IR AR	Pregnancy/Childbirth Benefit Rider
25985 (10/05)-IR AR	Legend Prescription Drug Expense Rider
25987 (10/05)-IR	Outpatient Accident Expense Benefit Rider
26028 (10/05)-IR	[Preventive Plus] Benefit Rider
26029 (10/05)-IR	Outpatient Speech Therapy, Physical Therapy & Occupational Therapy Rider

Flesch Reading Ease Score: 46.0



Susan Dew, Vice President and Chief Compliance Officer

June 18, 2008

Date

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY OUTLINE OF COVERAGE FOR FORM 26026 PPO-IP AR

- 1. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY**.
- 2. CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) COVERAGE** - The plan provides coverage for catastrophic expenses with the option of obtaining services through a Preferred Provider Organization, payable at a higher coinsurance level. The plan has a [\$5,000,000] Lifetime Maximum Amount and a [\$1,000,000] Aggregate Maximum Amount for all covered Injuries and Sicknesses. Covered Expenses are subject to a Deductible, unless otherwise stated.
- 3. BENEFITS** - For the purpose of this Outline of Coverage, Insured Person means You and Your Covered Dependents who are covered under the Policy.

The plan pays for Covered Expenses incurred under the Policy, subject to a [\$5,000,000] Lifetime Maximum Amount for all Injuries and Sicknesses per Insured Person. The plan pays for Covered Expenses incurred under the Policy, subject to a [\$1,000,000 Aggregate Maximum Amount] for any one covered Injury or Sickness for each Insured Person. Unless otherwise stated, all Covered Expenses are subject to the Maximum Benefits as shown in the Policy, Deductibles, Copayments, [Coinsurance Maximum] and Coinsurance shown below:

Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care providers of their choice; however, if Covered Expenses are incurred from services provided by a non-PPO provider, Benefits will be less than the amount that would have otherwise been payable for Covered Expenses incurred from services provided by a PPO provider as shown below.

Deductible:

The Deductible applies to each Insured Person and for each [Calendar Year.]

<u>PPO Provider</u>	<u>Non-PPO Provider</u>
<input type="checkbox"/> \$1,500	[\$3,000]
<input type="checkbox"/> \$2,000	\$4,000
<input type="checkbox"/> \$2,500	\$5,000
<input type="checkbox"/> \$3,000	\$6,000
<input type="checkbox"/> \$3,500	\$7,000
<input type="checkbox"/> \$5,000	\$10,000
<input type="checkbox"/> \$7,500	\$15,000
<input type="checkbox"/> \$10,000]	\$20,000]

<u>PPO Provider</u>	<u>Non-PPO Provider</u>
---------------------	-------------------------

Coinsurance Maximum:	[\$4,000] [\$6,000] [\$8,000]	[\$8,000] [\$12,000] [\$16,000]
Coinsurance:	<input type="checkbox"/> 70%] <input type="checkbox"/> 80%] <input type="checkbox"/> 90%] of Covered Expenses	<input type="checkbox"/> 50%] <input type="checkbox"/> 60%] <input type="checkbox"/> 70%] of Covered Expenses

COVERED EXPENSES

Covered Expenses means [Usual and Customary] Charges for the services, supplies, care or treatment covered under this Policy which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay and are not otherwise excluded or limited herein. They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a [Usual and Customary] Charge or fee which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force.

[Any charges in excess of the Maximum Benefit, if any, will not be considered a Covered Expense.]

Covered Expenses under the Riders, if any, may or may not be considered Covered Expenses under the Policy.

Inpatient Hospital Services - Covered Expenses incurred for services and supplies provided by the Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's intensive care or cardiac care unit (in lieu of Benefit amount payable for Hospital room and board) and miscellaneous medical services and supplies necessary for the treatment of the Insured Person during that [Calendar Year].

Covered Expenses will also include x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

The fees charged for take home drugs, personal convenience items, or items not intended primarily for use of the Insured Person while Hospital Confined are not Covered Expenses.

Physician Visits while Hospital Confined - Covered Expenses incurred for visits by a Physician, other than the surgeon, while Hospital Confined, not exceed a [\$100] Maximum Benefit, per Insured Person, per day.

Surgeon Benefit - Covered Expenses incurred [while Hospital Confined or in an Outpatient Surgery Facility] for services by the Physician performing Surgery.

If two or more Surgeries are performed at the same time through separate incisions, We will consider the one providing the largest Benefit. We will also consider [50%] of the Benefits otherwise payable for the other Surgeries performed at the same time.

We will not consider more than one Surgery performed through the same incision during the same operation; however, We will consider the Surgery providing the largest Benefit.

If it is recommended that You have Physical Therapy in lieu of Surgery, We may consider Physical Therapy as an alternative to Surgery. Such Physical Therapy must be in accordance with a Treatment Plan approved by Us. Covered Expenses incurred under this Surgeon Benefit for Physical Therapy will be counted toward the applicable Surgeon Benefit.

Assistant Surgeon Benefit - Covered Expenses incurred for services by the Physician assisting the Physician performing Surgery.

Anesthesiologist Benefit - Covered Expenses incurred for services by the Physician providing anesthesia during Surgery.

Outpatient Surgery Facility Charges - Covered Expenses incurred for services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to:

1. Use of operating room and recovery room;
2. Administration of drugs and medicines during Surgery;
3. Dressings, casts, splints; and
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

Second Surgical Opinion - Covered Expenses incurred for services by a Physician for a second opinion. The Physician providing the second opinion cannot be financially associated with the referring Physician or perform or assist in the Surgery in order for services to be considered a Covered Expense under the Policy.

If the second opinion disagrees with the first, a third opinion will also be considered a Covered Expense.

Durable Medical Equipment and Prosthetic Devices - Covered Expenses incurred for the rental of durable medical equipment not to exceed the actual purchase price of such equipment, and the purchase, fitting, repair and replacement of fitted prosthetic devices which replace a natural limb or eye, when ordered or prescribed by a Physician for use by the Insured Person.

The durable medical equipment or prosthetic device must be for use solely by the Insured Person for the treatment of a Sickness or Injury which occurred while such Insured Person's coverage is in force.

Routine maintenance and repairs of rental equipment are not Covered Expenses.

Covered Expenses will not exceed a Maximum Benefit of [\$5,000] per Insured Person, per [Calendar Year].

Outpatient Diagnostic Services - Covered Expenses incurred [within [21] days of a Surgery or Hospital Confinement] for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury [that results in Surgery or Hospital Confinement]. [Covered Expenses include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests. [Please refer to the CASE MANAGEMENT provision shown in the Policy for Pre-Notification Requests of Non-Emergency Admissions.]]

Covered Expenses do not include routine physical examinations or checkups.

[Covered Expenses will not exceed a Maximum Benefit of [\$10,000] per Insured Person, per Calendar Year and must be related to and necessary for the diagnosis and treatment of the Sickness or Injury that results in Surgery or Hospital Confinement.] A [☐ \$50] [☐ \$100] [☐ \$150] Copayment, per Insured Person, per 24 hour period, will apply.

Ambulance Transport - Covered Expenses incurred for Ambulance transportation to a Hospital, provided the Insured Person is Confined to the Hospital. Covered Expenses will not exceed a Maximum Benefit of [\$500] per Insured Person, per trip.

Chemotherapy - Covered Expenses incurred for chemotherapy received while Hospital Confined or on an outpatient basis. The condition for which chemotherapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Covered Expenses incurred with an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected.

Covered Expenses incurred without an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected, up to a Maximum Benefit of [\$1,500] per Insured Person, per day.

Radiation Therapy - Covered Expenses incurred for radiation therapy received while Hospital Confined or on an outpatient basis. The condition for which radiation therapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Covered Expenses incurred with an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected.

Covered Expenses incurred without an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected, up to a Maximum Benefit of [\$1,250] per Insured Person, per day.

Transplants - Covered Expenses include Transplant Procedures incurred during a Transplant Benefit Period.

Covered Expenses for Transplant Procedures include:

1. Inpatient and outpatient Hospital services;
2. Services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure;
3. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under the Policy. Covered Expenses are limited to the actual procurement expenses, and will not be more than any maximums under the Policy applicable to the recipient;
4. [Usual and Customary] Charges for Travel and Accommodation Expenses related to a Transplant Procedure for the transplant recipient and one companion during a Transplant Benefit Period, provided the transplant facility is more than [300] miles from the Insured Person's home. If the recipient is a minor, Travel and Accommodation Expenses for two companions may be covered. Benefits for Travel and Accommodation Expenses are subject to the Travel and Accommodation Expense maximum[.];
5. Rental of durable medical equipment for use outside the Hospital. Covered Expenses are limited to the purchase price of the same equipment;
6. Prescription Drugs, including immunosuppressive drugs;
7. Oxygen;
8. Speech therapy, occupational therapy, Physical Therapy and chemotherapy;
9. Services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy; and
10. Surgical dressings and supplies.]

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee in order for Us to direct the Insured Person to an appropriate Designated Transplant Facility. Covered Expenses for a live donor shall be paid to the extent that benefits remain and are available under this Policy for the Insured Person receiving the transplant, and after all Covered Expenses for the Insured Person has been paid. Benefits are not payable for animal organ or artificial organ transplants or for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a Physician. Benefits are not payable for Covered Expenses incurred beyond the Transplant Benefit Period. Medically Necessary transplants not specifically defined as a Transplant Procedure under the Policy, which are not determined to be Experimental or Investigational Medicine will be payable the same as any other Transplant Procedure under the Policy in accordance with the provisions of the Policy.

Covered Expenses incurred for Transplant Procedures in a Designated Transplant Facility will be considered at [100%], with a Maximum Benefit payable for incurred Travel and Accommodation Expenses of [\$150] per day and [\$3,000] per Transplant Benefit Period.

Covered Expenses incurred for Transplant Procedures outside a Designated Transplant Facility will be considered at the Coinsurance amount selected with a Maximum Benefit payable of [\$100,000] per Transplant Procedure. [Travel and Accommodation Expenses incurred will not be considered as Covered Expenses.]

Musculoskeletal Disorders - Covered Expenses incurred for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder, on the same basis as that provided for any other musculoskeletal disorder in the body, whether prescribed or administered by a Physician or dentist. Treatment shall include both surgical and nonsurgical procedures, and shall be provided for the diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

Child Health Supervision Services - Covered Expenses incurred for each Covered Dependent from the moment of birth to age eighteen (18) years. In keeping with prevailing medical standards, such services shall include:

1. anticipatory guidance;
2. developmental assessment;
3. laboratory tests;
4. appropriate immunizations
5. a medical history; and
6. physical examination.

Benefits will be payable for 20 visits provided by or under the supervision of a single Physician during the course of one visit, at approximately the following intervals: birth; two weeks; two, four, six, nine, twelve, fifteen and eighteen months and two, three, four, five, six, eight, ten, twelve, fourteen, sixteen and eighteen years.

Benefits payable will not exceed current reimbursement levels for the same services under the Medicaid Early Periodic Screening Diagnosis and Treatment program in the State of Arkansas.

Benefits for recommended immunization services shall be exempt from any Coinsurance, Deductible or dollar limit provisions.

Maternity Stay Requirements For Covered Maternity Care - This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Expenses for a normal childbirth or cesarean section delivery that is covered by an optional Maternity Benefit Rider or for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section. Any normal delivery is subject to the Maximum Benefit for Pregnancy/Childbirth as stated in the optional Maternity Benefit Rider.

Medical Foods and Low Protein Modified Food Products - Covered Expenses incurred for the treatment of a Covered Dependent inflicted with phenylketonuria if:

1. The medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemia and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Physician; and
3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the [two thousand four hundred dollars (\$2,400)] per year per person income tax credit allowed.

Diabetes - Covered Expenses incurred for diabetes self-management training, supplies and related services for the treatment of Type I, Type II and gestational diabetes when determined Medically Necessary by Your Physician or other licensed health care provider.

Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Impairment or Loss of Speech or Hearing - Covered Expenses incurred for the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

Colorectal Cancer Screening - Covered expenses incurred for colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and experiencing bleeding from the rectum or blood in the stool or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than 5 days as determined by a licensed Physician.

For the purpose of this benefit "high risk for colorectal cancer" means: Individuals over 50 years of age or who face a high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

Outpatient Contraceptive Services and Devices - Covered Expenses incurred for Outpatient Contraceptive Services and Devices including closed formularies; however, formularies must include implant and injectable contraceptive drugs, and intrauterine devices.

Covered Expenses do not include charges for abortion, an abortifacient or any U.S. Food and Drug Administration approved emergency contraception.

Outpatient Contraceptive benefits are subject to the same Deductibles and Coinsurances as prescription drugs.

4. EXCLUSIONS AND LIMITATIONS - We will not provide any Benefits for charges resulting from or in connection with:

1. Any care not Medically Necessary or charges for which Benefits are not specifically provided for in the Policy;
2. Any act of war, declared or undeclared;
3. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
4. Any routine physical examination, unless otherwise stated in the Policy;
5. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Worker's Compensation Act, Occupational Disease Act, or similar act or law, unless the Insured Person is self-employed;
6. Mental or Nervous Disorders, unless otherwise stated in the Policy;
7. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, unless taken as prescribed by a Physician;
8. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, directly or indirectly, unless taken as prescribed by a Physician;
9. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated in the Policy;
10. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
11. Spinal manipulations and manual manipulative treatment or therapy;
12. Weight loss or modification, or complications arising therefrom, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
13. Breast reduction or augmentation unless necessary in connection with breast reconstructive Surgery following a mastectomy;
14. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
15. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
16. Routine newborn care, unless otherwise stated in the Policy;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;
20. Physical examinations required for school events, camp, employment, licensing and insurance are expressly excluded;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;

22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated in the Policy;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury, and while Hospital Confined or in an Outpatient Surgery Facility);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Hernia, hemorrhoids, tonsils, adenoids, middle ear disorders, myringotomy; or any disease or disorder of the reproductive organs unless the loss is incurred 6 months after the Insured Person becomes covered under this Policy;
30. Expenses incurred for prescription drugs, except if added by Rider;
31. Normal pregnancy, except for Complications of Pregnancy, except Benefits added by Rider, if any; and
32. Treatment, services or supplies received outside the U.S. or Canada. However, Benefits will be payable for Covered Expenses incurred as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada. In no event will Benefits be payable beyond the first 30 days of travel outside of the U.S. or Canada.

Pre-Existing Condition - We will not provide Benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least one year after the Effective Date of Coverage for an Insured Person.

Coverage After Age 65 or Earlier Medicare Eligibility - When an Insured Person attains age 65 or becomes eligible for Medicare, whichever happens first, the Benefits of the Policy and its attachments, if any, are payable only to the extent that Covered Expenses are not paid by Medicare and they would otherwise be payable under the Policy. The Benefits will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in the Policy.

5. **RENEWABILITY** - The Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.

6. TERMINATION OF COVERAGE –

You

Your coverage will terminate and no Benefits will be payable under the Policy and any attached Riders:

1. At the end of the period for which premium has been paid;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
6. On the date We elect to discontinue all coverage in Your state. We will give You and the proper state authority at least 180 days notice before the date coverage will be discontinued; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy on:

1. The date Your coverage terminates;
2. The date such Dependent ceases to be an Eligible Dependent; or

3. The date We receive Your written request to terminate a dependent's coverage.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

Special Continuation Provision For Dependents

Your Covered Dependents may continue their same (or substantially similar) coverage under a new Policy without evidence of insurability if their coverage under this Policy would otherwise terminate because they cease to be an Eligible Dependent for any of the following reasons:

1. Divorce, legal separation, Your death; or
2. A dependent child reaches the Limiting Age.

To continue coverage, You or Your Covered Dependent must request continuation of coverage by application or written notification within 31 days of the date coverage would otherwise terminate and pay any required premium.

7. RIDER BENEFITS –

Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Rider (Form Number 26029 (10/05)-IR) – Covered Expenses incurred for Speech Therapy, Physical Therapy and Occupational Therapy that is related to and necessary for the treatment of a Sickness or Injury. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit Amount,] [Copayment,] [Coinsurance] and any other limitation shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.] In order to be considered a Covered Expense, therapy services must commence within 14 days of a covered Hospital Confinement or Surgery and be rendered in the 90 days immediately following the related covered Hospital Confinement or Surgery. Therapy provided beyond 90 days following a Hospital Confinement or Surgery will not be considered a Covered Expense.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Maximum Benefit, per Insured Person, per week: [3] visits		
Not to exceed a [\$150] Maximum Benefit, per Insured Person, per day:		
Copayment, per visit: <input type="checkbox"/> \$25 <input type="checkbox"/> \$35 <input type="checkbox"/> \$50		

Outpatient Accident Expense Benefit Rider (Form Number 25987(10/05)-IR) - Covered Expenses incurred by an Insured Person while the Rider is in force, for the Medically Necessary treatment of an Injury while not Hospital Confined. Benefit is subject to the following conditions: 1) Initial treatment by a Physician must begin within [72] hours of the Injury; and 2) Any treatment of the Injury, beyond the initial treatment, must be received within [45 days] of the Injury. The Benefits provided by this Rider will not duplicate Benefits provided under the Policy and any other rider and are subject to the [Rider Deductible, Coinsurance and the Maximum Benefit] shown for this Rider in the Policy Schedule. [Benefit paid under this Rider and amounts used to satisfy the Rider Deductible will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

Coinsurance	[100%]
Maximum Benefit, per Insured Person, per Injury	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000
Deductible, per Injury	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200

Pregnancy/Childbirth Benefit Rider – (Form Number 25984 (10/05)-IR) AR – Covered Expenses incurred for normal pregnancy and childbirth at a Coinsurance amount in accordance with the length of time the Rider is in force. Covered Expenses will not exceed the Maximum Benefit selected. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the Maximum Benefit Amount [Copayment,] [and Coinsurance] shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

[0-10] months in force	[0%] of Maximum Benefit selected
[11-24] months in force	[50%] of Maximum Benefit selected
[25] months in force and over	[100%] of Maximum Benefit selected

Maximum Benefit, per in vitro fertilization procedure ☐ \$2,000
and/or pregnancy/childbirth, for You or Your
Covered Dependent Spouse

Lifetime Maximum for In Vitro Fertilization
Benefits: [\$15,000]

Air Ambulance Rider - (Form Number 25983 (10/05)-IR)- Covered Expenses incurred while the Rider is in force for Air Ambulance transportation to the nearest available medical facility that can provide adequate care in the event of a Medical Emergency, as defined in the Policy, at the Coinsurance amount selected. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit Amount,] [Copayment] [and Coinsurance] and any other limitation shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.] Covered Expenses will not exceed the base rate or the Maximum Benefit.

Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%
Base rate	[\$2,500]
Plus an additional	[\$50] per mile
Maximum Benefit, per Insured Person, per Calendar Year	[\$5,000]

Continued Care Benefit Rider – Form Number 25883 (10/05)-IR) AR – Covered Expenses incurred for Skilled Nursing Care, Home Health Care, Private Duty Nurse, or Hospice Care, following a covered Hospital Confinement for Medically Necessary continued care in accordance with a Treatment Plan, and as described in the rider. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the Maximum Benefits, Coinsurance and other limitations shown for this Rider [and the Policy Deductible shown] in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

PPO Provider

Non-PPO Provider

Skilled Nursing Care

Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Limited to [30 days] per Insured Person, per [Calendar Year]		

Maximum Benefit per Insured
Person, per day [\$250]

Home Health Care

Coinsurance ☐ 70% ☐ 80% ☐ 90% ☐ 50% ☐ 60% ☐ 70%

Limited to [80 visits] per Insured Person,
per [Calendar Year]

Not to exceed a [\$50] Maximum Benefit
per Insured Person, per day

Private Duty Nursing

Coinsurance ☐ 70% ☐ 80% ☐ 90% ☐ 50% ☐ 60% ☐ 70%

Limited to [40 eight-hour shifts] per
Insured Person, per [Calendar Year]

Not to exceed a [\$50] Maximum Benefit
per Insured Person, per shift

Hospice Care

Coinsurance ☐ 70% ☐ 80% ☐ 90% ☐ 50% ☐ 60% ☐ 70%

Not to exceed a [\$5,000] Maximum Benefit
per Insured Person, per lifetime

Legend Prescription Drug Expense Rider (Form Number 25985 (10/05)-IR) AR - We will pay a benefit if an Insured Person incurs Covered Expenses for Sickness or Injury. This benefit is the amount equal to the actual charge based on Participating Pharmacy prices for a Covered Expense, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

Deductible, per Calendar Year, per Insured Person ☐ \$50 ☐ \$100

Participating Pharmacy

(Not to exceed a 30 day supply)

Generic Drugs

We pay [100%] less the [\$15] Copayment

Formulary Drugs

We pay [50%], You pay the remainder

Non-Formulary Drugs

We pay [25%], You pay the remainder

Non-Participating Pharmacy

(Not to exceed a 30 day supply)

Generic Drugs

We pay [75%] less the [\$15] Copayment

Formulary Drugs

We pay [25%], You pay the remainder

Non-Formulary Drugs

We pay [0%], You pay the remainder

Mail Service Legend Prescription Drugs

(Not to exceed a 90 day supply through Our designated mail service program)

Generic Drugs

We pay [100%] less the [\$30] Copayment

Formulary Drugs

We pay [50%], You pay the remainder

Non-Formulary Drugs

We pay [25%], You pay the remainder

Benefit Maximum

Per Insured Person

[\$1,500] per Calendar Year

[PREVENTIVE PLUS] Benefit Rider (Form Number 26028 (10/05)-IR) – Benefits under the Rider are provided for [Medically Necessary] [non-Covered Expenses] for [Physician office visits, except for visits related to Mental or Nervous Disorders or fertility treatment;] [Allergy injections;] [Outpatient Diagnostic expenses not otherwise considered a Covered Expense under the Policy or any attached Riders;] [Emergency Room services not otherwise considered a Covered Expense under the Policy or any attached Riders; and] [Spinal manipulations]. [Routine preventive health care services, including but not limited to routine physical exams and related laboratory and x-rays services and immunizations, not otherwise paid under the Policy; and] [Acupuncture] will also be considered under the Rider.

All Benefits under the Rider are subject to subject to [Usual and Customary Charges][the Maximum Allowable Charge (MAC)], based on the Annual [PREVENTIVE PLUS] Benefit Amount selected, subject to a Quarterly Benefit Accumulation Amount.

ANNUAL [PREVENTIVE PLUS] BENEFIT AMOUNT:	QUARTERLY BENEFIT ACCUMULATION AMOUNT: (per quarterly Rider anniversary for You and Your Covered Dependents, if any)
<input type="checkbox"/> \$250	<input type="checkbox"/> \$62.50
<input type="checkbox"/> \$500	<input type="checkbox"/> \$125.00
<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$250.00
<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$500.00

Benefits under the Rider can accumulate if unused; however, there are limits to the amount that can accumulate. If there is more than one Insured Person covered under the Rider, there are limits to the maximum amount available to each Insured Person. Any Pre-Existing Condition limitations, conditions excluded by Waiver or Benefits paid under the Policy or any attached Riders, will not be considered under this Rider.

Benefits will be paid from the [PREVENTIVE PLUS] Benefit Amount on the date the services are rendered. Benefits accumulated subsequent to the date the services are rendered will not be used to pay benefits on services rendered before the accumulation date. In order for benefits to be considered under the Rider, services must be rendered during the time period for which premium has been paid for the Rider.

Emergency Services Benefit Rider (Form Number 26032 (10/05)-IR or 26032 PPO (10/05)-IR)- Covered Expenses incurred while the Rider is in force for Emergency Treatment of a Sickness or Injury not resulting in Hospital Confinement. The Benefits provided by this Rider will not duplicate the Benefits provided under the Policy and any other rider and are subject to the [[Policy Deductible] shown in the POLICY SCHEDULE] [and the [Copayment,][and Coinsurance][and Maximum Benefit] shown for this Rider in the POLICY SCHEDULE.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance [Not to exceed a [\$1,000][\$2,000] Maximum Benefit per Insured Person, per visit]	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
[Physician's Office or Urgent Care Center Copayment, per visit <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000]]		
[Hospital Emergency Room Copayment, per visit <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000]]		

Physician's Office Visit Benefit Rider[*] (Form Number 25886-IP) - We will pay Covered Expenses incurred by an Insured Person, while this Rider is in force, for Medically Necessary visits to the Physician's office or clinic and for related care services provided by the Physician as a part of such visit. Benefits payable under this Rider are not subject to the Policy Deductible.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Copayment, per Insured Person, per visit	[\$30]	[\$30]
Daily Maximum Benefit, per Insured, Person per visit	[\$125]	[\$100]

Maximum Number of visits per calendar quarter
For You and Your Covered Dependent Spouse

☐ 1 ☐ 2 visits each

Maximum Number of visits per calendar quarter
For Your Covered Dependent Child(ren)

☐ 2 ☐ 4 visits each

[*The **Sickness Exclusion**, as shown in the EXCLUSIONS AND LIMITATIONS section of this Policy, does not apply to this Rider.]

8. **RIGHT TO RETURN POLICY** - It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return the Policy to Us at Our administrative office in North Richland Hills, Texas, within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Policy Date, refund all premiums paid and treat the Policy as if it were never issued.
9. **PREMIUMS** - We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Policyholder written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.

Initial Premium for Policy	_____
[Policy Fee	_____]
Rider Premium	_____
Total Initial Premium due with Application	_____

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY OUTLINE OF COVERAGE FOR FORM 26026 PPO-IP AR

NOTICE: Read this Outline of Coverage carefully. It is not identical to the Outline of Coverage provided upon application and the coverage originally applied for has not been issued.

- 1. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**
- 2. CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) COVERAGE** - The plan provides coverage for catastrophic expenses with the option of obtaining services through a Preferred Provider Organization, payable at a higher coinsurance level. The plan has a [\$5,000,000] Lifetime Maximum Amount and a [\$1,000,000] Aggregate Maximum Amount for all covered Injuries and Sicknesses. Covered Expenses are subject to a Deductible, unless otherwise stated.
- 3. BENEFITS** - For the purpose of this Outline of Coverage, Insured Person means You and Your Covered Dependents who are covered under the Policy.

The plan pays for Covered Expenses incurred under the Policy, subject to a [\$5,000,000] Lifetime Maximum Amount for all Injuries and Sicknesses per Insured Person. The plan pays for Covered Expenses incurred under the Policy, subject to a [\$1,000,000 Aggregate Maximum Amount] for any one covered Injury or Sickness for each Insured Person. Unless otherwise stated, all Covered Expenses are subject to the Maximum Benefits as shown in the Policy, Deductibles, Copayments, [Coinsurance Maximum] and Coinsurance shown below:

Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care providers of their choice; however, if Covered Expenses are incurred from services provided by a non-PPO provider, Benefits will be less than the amount that would have otherwise been payable for Covered Expenses incurred from services provided by a PPO provider as shown below.

Deductible:

The Deductible applies to each Insured Person and for each [Calendar Year.]

<u>PPO Provider</u>	<u>Non-PPO Provider</u>
<input type="checkbox"/> \$1,500	[\$3,000
<input type="checkbox"/> \$2,000	\$4,000
<input type="checkbox"/> \$2,500	\$5,000
<input type="checkbox"/> \$3,000	\$6,000
<input type="checkbox"/> \$3,500	\$7,000
<input type="checkbox"/> \$5,000	\$10,000
<input type="checkbox"/> \$7,500	\$15,000
<input type="checkbox"/> \$10,000]	\$20,000]

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance Maximum:	[\$4,000] [\$6,000] [\$8,000]	[\$8,000] [\$12,000] [\$16,000]
Coinsurance:	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90% of Covered Expenses	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70% of Covered Expenses

COVERED EXPENSES

Covered Expenses means [Usual and Customary] Charges for the services, supplies, care or treatment covered under this Policy which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay and are not otherwise excluded or limited herein. They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a [Usual and Customary] Charge or fee which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force.

[Any charges in excess of the Maximum Benefit, if any, will not be considered a Covered Expense.]

Covered Expenses under the Riders, if any, may or may not be considered Covered Expenses under the Policy.

Inpatient Hospital Services - Covered Expenses incurred for services and supplies provided by the Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's intensive care or cardiac care unit (in lieu of Benefit amount payable for Hospital room and board) and miscellaneous medical services and supplies necessary for the treatment of the Insured Person during that [Calendar Year].

Covered Expenses will also include x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

The fees charged for take home drugs, personal convenience items, or items not intended primarily for use of the Insured Person while Hospital Confined are not Covered Expenses.

Physician Visits while Hospital Confined - Covered Expenses incurred for visits by a Physician, other than the surgeon, while Hospital Confined, not exceed a [\$100] Maximum Benefit, per Insured Person, per day.

Surgeon Benefit - Covered Expenses incurred [while Hospital Confined or in an Outpatient Surgery Facility] for services by the Physician performing Surgery.

If two or more Surgeries are performed at the same time through separate incisions, We will consider the one providing the largest Benefit. We will also consider [50%] of the Benefits otherwise payable for the other Surgeries performed at the same time.

We will not consider more than one Surgery performed through the same incision during the same operation; however, We will consider the Surgery providing the largest Benefit.

If it is recommended that You have Physical Therapy in lieu of Surgery, We may consider Physical Therapy as an alternative to Surgery. Such Physical Therapy must be in accordance with a Treatment Plan approved by Us. Covered Expenses incurred under this Surgeon Benefit for Physical Therapy will be counted toward the applicable Surgeon Benefit.

Assistant Surgeon Benefit - Covered Expenses incurred for services by the Physician assisting the Physician performing Surgery.

Anesthesiologist Benefit - Covered Expenses incurred for services by the Physician providing anesthesia during Surgery.

Outpatient Surgery Facility Charges - Covered Expenses incurred for services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to:

1. Use of operating room and recovery room;
2. Administration of drugs and medicines during Surgery;
3. Dressings, casts, splints; and
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

Second Surgical Opinion - Covered Expenses incurred for services by a Physician for a second opinion. The Physician providing the second opinion cannot be financially associated with the referring Physician or perform or assist in the Surgery in order for services to be considered a Covered Expense under the Policy.

If the second opinion disagrees with the first, a third opinion will also be considered a Covered Expense.

Durable Medical Equipment and Prosthetic Devices - Covered Expenses incurred for the rental of durable medical equipment not to exceed the actual purchase price of such equipment, and the purchase, fitting, repair and replacement of fitted prosthetic devices which replace a natural limb or eye, when ordered or prescribed by a Physician for use by the Insured Person.

The durable medical equipment or prosthetic device must be for use solely by the Insured Person for the treatment of a Sickness or Injury which occurred while such Insured Person's coverage is in force.

Routine maintenance and repairs of rental equipment are not Covered Expenses.

Covered Expenses will not exceed a Maximum Benefit of [\$5,000] per Insured Person, per [Calendar Year].

Outpatient Diagnostic Services - Covered Expenses incurred [within [21] days of a Surgery or Hospital Confinement] for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury [that results in Surgery or Hospital Confinement]. [Covered Expenses include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests. [Please refer to the CASE MANAGEMENT provision shown in the Policy for Pre-Notification Requests of Non-Emergency Admissions.]]

Covered Expenses do not include routine physical examinations or checkups.

[Covered Expenses will not exceed a Maximum Benefit of [\$10,000] per Insured Person, per Calendar Year and must be related to and necessary for the diagnosis and treatment of the Sickness or Injury that results in Surgery or Hospital Confinement.] A ☐ \$50 ☐ \$100 ☐ \$150 Copayment, per Insured Person, per 24 hour period, will apply.

Ambulance Transport - Covered Expenses incurred for Ambulance transportation to a Hospital, provided the Insured Person is Confined to the Hospital. Covered Expenses will not exceed a Maximum Benefit of [\$500] per Insured Person, per trip.

Chemotherapy - Covered Expenses incurred for chemotherapy received while Hospital Confined or on an outpatient basis. The condition for which chemotherapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Covered Expenses incurred with an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected.

Covered Expenses incurred without an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected, up to a Maximum Benefit of [\$1,500] per Insured Person, per day.

Radiation Therapy - Covered Expenses incurred for radiation therapy received while Hospital Confined or on an outpatient basis. The condition for which radiation therapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Covered Expenses incurred with an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected.

Covered Expenses incurred without an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected, up to a Maximum Benefit of [\$1,250] per Insured Person, per day.

Transplants - Covered Expenses include Transplant Procedures incurred during a Transplant Benefit Period. Covered Expenses for Transplant Procedures include:

1. Inpatient and outpatient Hospital services;
2. Services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure;
3. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under the Policy. Covered Expenses are limited to the actual procurement expenses, and will not be more than any maximums under the Policy applicable to the recipient;
4. [Usual and Customary] Charges for Travel and Accommodation Expenses related to a Transplant Procedure for the transplant recipient and one companion during a Transplant Benefit Period, provided the transplant facility is more than [300] miles from the Insured Person's home. If the recipient is a minor, Travel and Accommodation Expenses for two companions may be covered. Benefits for Travel and Accommodation Expenses are subject to the Travel and Accommodation Expense maximum[.];
5. Rental of durable medical equipment for use outside the Hospital. Covered Expenses are limited to the purchase price of the same equipment;
6. Prescription Drugs, including immunosuppressive drugs;
7. Oxygen;
8. Speech therapy, occupational therapy, Physical Therapy and chemotherapy;
9. Services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy; and
10. Surgical dressings and supplies.]

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee in order for Us to direct the Insured Person to an appropriate Designated Transplant Facility. Covered Expenses for a live donor shall be paid to the extent that benefits remain and are available under this Policy for the Insured Person receiving the transplant, and after all Covered Expenses for the Insured Person has been paid. Benefits are not payable for animal organ or artificial organ transplants or for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a Physician. Benefits are not payable for Covered Expenses incurred beyond the Transplant Benefit Period. Medically Necessary transplants not specifically defined as a Transplant Procedure under the Policy, which are not determined to be Experimental or Investigational Medicine will be payable the same as any other Transplant Procedure under the Policy in accordance with the provisions of the Policy.

Covered Expenses incurred for Transplant Procedures in a Designated Transplant Facility will be considered at [100%], with a Maximum Benefit payable for incurred Travel and Accommodation Expenses of [\$150] per day and [\$3,000] per Transplant Benefit Period.

Covered Expenses incurred for Transplant Procedures outside a Designated Transplant Facility will be considered at the Coinsurance amount selected with a Maximum Benefit payable of [\$100,000] per Transplant Procedure. [Travel and Accommodation Expenses incurred will not be considered as Covered Expenses.]

Musculoskeletal Disorders - Covered Expenses incurred for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder, on the same basis as that provided for any other musculoskeletal disorder in the body, whether prescribed or administered by a Physician or dentist. Treatment shall include both surgical and

nonsurgical procedures, and shall be provided for the diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

Child Health Supervision Services - Covered Expenses incurred for each Covered Dependent from the moment of birth to age eighteen (18) years. In keeping with prevailing medical standards, such services shall include:

1. anticipatory guidance;
2. developmental assessment;
3. laboratory tests;
4. appropriate immunizations
5. a medical history; and
6. physical examination.

Benefits will be payable for 20 visits provided by or under the supervision of a single Physician during the course of one visit, at approximately the following intervals: birth; two weeks; two, four, six, nine, twelve, fifteen and eighteen months and two, three, four, five, six, eight, ten, twelve, fourteen, sixteen and eighteen years.

Benefits payable will not exceed current reimbursement levels for the same services under the Medicaid Early Periodic Screening Diagnosis and Treatment program in the State of Arkansas.

Benefits for recommended immunization services shall be exempt from any Coinsurance, Deductible or dollar limit provisions.

Maternity Stay Requirements For Covered Maternity Care - This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Expenses for a normal childbirth or cesarean section delivery that is covered by an optional Maternity Benefit Rider or for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section. Any normal delivery is subject to the Maximum Benefit for Pregnancy/Childbirth as stated in the optional Maternity Benefit Rider.

Medical Foods and Low Protein Modified Food Products - Covered Expenses incurred for the treatment of a Covered Dependent inflicted with phenylketonuria if:

1. The medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemia and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Physician; and
3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the [two thousand four hundred dollars (\$2,400)] per year per person income tax credit allowed.

Diabetes - Covered Expenses incurred for diabetes self-management training, supplies and related services for the treatment of Type I, Type II and gestational diabetes when determined Medically Necessary by Your Physician or other licensed health care provider.

Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Impairment or Loss of Speech or Hearing - Covered Expenses incurred for the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

Colorectal Cancer Screening - Covered expenses incurred for colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and experiencing bleeding from the rectum or blood in the stool or a change in bowel habits,

such as diarrhea, constipation, or narrowing of the stool that lasts more than 5 days as determined by a licensed Physician.

For the purpose of this benefit "high risk for colorectal cancer" means: Individuals over 50 years of age or who face a high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

Outpatient Contraceptive Services and Devices - Covered Expenses incurred for Outpatient Contraceptive Services and Devices including closed formularies; however, formularies must include implant and injectable contraceptive drugs, and intrauterine devices.

Covered Expenses do not include charges for abortion, an abortifacient or any U.S. Food and Drug Administration approved emergency contraception.

Outpatient Contraceptive benefits are subject to the same Deductibles and Coinsurances as prescription drugs.

4. EXCLUSIONS AND LIMITATIONS - We will not provide any Benefits for charges resulting from or in connection with:

1. Any care not Medically Necessary or charges for which Benefits are not specifically provided for in the Policy;
2. Any act of war, declared or undeclared;
3. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
4. Any routine physical examination, unless otherwise stated in the Policy;
5. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Worker's Compensation Act, Occupational Disease Act, or similar act or law, unless the Insured Person is self-employed;
6. Mental or Nervous Disorders, unless otherwise stated in the Policy;
7. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, unless taken as prescribed by a Physician;
8. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, directly or indirectly, unless taken as prescribed by a Physician;
9. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated in the Policy;
10. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
11. Spinal manipulations and manual manipulative treatment or therapy;
12. Weight loss or modification, or complications arising therefrom, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
13. Breast reduction or augmentation unless necessary in connection with breast reconstructive Surgery following a mastectomy;
14. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
15. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
16. Routine newborn care, unless otherwise stated in the Policy;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;

20. Physical examinations required for school events, camp, employment, licensing and insurance are expressly excluded;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;
22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated in the Policy;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury, and while Hospital Confined or in an Outpatient Surgery Facility);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Hernia, hemorrhoids, tonsils, adenoids, middle ear disorders, myringotomy; or any disease or disorder of the reproductive organs unless the loss is incurred 6 months after the Insured Person becomes covered under this Policy;
30. Expenses incurred for prescription drugs, except if added by Rider;
31. Normal pregnancy, except for Complications of Pregnancy, except Benefits added by Rider, if any; and
32. Treatment, services or supplies received outside the U.S. or Canada. However, Benefits will be payable for Covered Expenses incurred as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada. In no event will Benefits be payable beyond the first 30 days of travel outside of the U.S. or Canada.

Pre-Existing Condition - We will not provide Benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least one year after the Effective Date of Coverage for an Insured Person.

Coverage After Age 65 or Earlier Medicare Eligibility - When an Insured Person attains age 65 or becomes eligible for Medicare, whichever happens first, the Benefits of the Policy and its attachments, if any, are payable only to the extent that Covered Expenses are not paid by Medicare and they would otherwise be payable under the Policy. The Benefits will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in the Policy.

5. **RENEWABILITY** - The Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.

6. TERMINATION OF COVERAGE –

You

Your coverage will terminate and no Benefits will be payable under the Policy and any attached Riders:

1. At the end of the period for which premium has been paid;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
6. On the date We elect to discontinue all coverage in Your state. We will give You and the proper state authority at least 180 days notice before the date coverage will be discontinued; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy on:

1. The date Your coverage terminates;
2. The date such Dependent ceases to be an Eligible Dependent; or
3. The date We receive Your written request to terminate a dependent's coverage.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

Special Continuation Provision For Dependents

Your Covered Dependents may continue their same (or substantially similar) coverage under a new Policy without evidence of insurability if their coverage under this Policy would otherwise terminate because they cease to be an Eligible Dependent for any of the following reasons:

1. Divorce, legal separation, Your death; or
2. A dependent child reaches the Limiting Age.

To continue coverage, You or Your Covered Dependent must request continuation of coverage by application or written notification within 31 days of the date coverage would otherwise terminate and pay any required premium.

7. RIDER BENEFITS –

Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Rider (Form Number 26029 (10/05)-IR) – Covered Expenses incurred for Speech Therapy, Physical Therapy and Occupational Therapy that is related to and necessary for the treatment of a Sickness or Injury. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit Amount,] [Copayment,] [Coinsurance] and any other limitation shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.] In order to be considered a Covered Expense, therapy services must commence within 14 days of a covered Hospital Confinement or Surgery and be rendered in the 90 days immediately following the related covered Hospital Confinement or Surgery. Therapy provided beyond 90 days following a Hospital Confinement or Surgery will not be considered a Covered Expense.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Maximum Benefit, per Insured Person, per week: [3] visits		
Not to exceed a [\$150] Maximum Benefit, per Insured Person, per day:		
Copayment, per visit: <input type="checkbox"/> \$25 <input type="checkbox"/> \$35 <input type="checkbox"/> \$50		

Outpatient Accident Expense Benefit Rider (Form Number 25987(10/05)-IR) - Covered Expenses incurred by an Insured Person while the Rider is in force, for the Medically Necessary treatment of an Injury while not Hospital Confined. Benefit is subject to the following conditions: 1) Initial treatment by a Physician must begin within [72] hours of the Injury; and 2) Any treatment of the Injury, beyond the initial treatment, must be received within [45 days] of the Injury. The Benefits provided by this Rider will not duplicate Benefits provided under the Policy and any other rider and are subject to the [Rider Deductible, Coinsurance and the Maximum Benefit] shown for this Rider in the Policy Schedule. [Benefit paid under this Rider and amounts used to satisfy the Rider Deductible will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

Coinsurance	[100%]
Maximum Benefit, per Insured Person, per Injury	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000
Deductible, per Injury	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200

Pregnancy/Childbirth Benefit Rider – (Form Number 25984 (10/05)-IR) AR – Covered Expenses incurred for normal pregnancy and childbirth at a Coinsurance amount in accordance with the length of time the Rider is in force. Covered Expenses will not exceed the Maximum Benefit selected. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the Maximum Benefit Amount [,Copayment,] [and Coinsurance] shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

[0-10] months in force	[0%] of Maximum Benefit selected
[11-24] months in force	[50%] of Maximum Benefit selected
[25] months in force and over	[100%] of Maximum Benefit selected
Maximum Benefit, per in vitro fertilization procedure and/or pregnancychildbirth, for You or Your Covered Dependent Spouse	<input type="checkbox"/> \$2,000
Lifetime Maximum for In Vitro Fertilization Benefits:	[\$15,000]

Air Ambulance Rider - (Form Number 25983 (10/05)-IR)- Covered Expenses incurred while the Rider is in force for Air Ambulance transportation to the nearest available medical facility that can provide adequate care in the event of a Medical Emergency, as defined in the Policy, at the Coinsurance amount selected. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit Amount,] [Copayment] [and Coinsurance] and any other limitation shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.] Covered Expenses will not exceed the base rate or the Maximum Benefit.

Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%
Base rate	[\$2,500]
Plus an additional	[\$50] per mile
Maximum Benefit, per Insured Person, per Calendar Year	[\$5,000]

Continued Care Benefit Rider – Form Number 25883 (10/05)-IR) AR – Covered Expenses incurred for Skilled Nursing Care, Home Health Care, Private Duty Nurse, or Hospice Care, following a covered Hospital Confinement for Medically Necessary continued care in accordance with a Treatment Plan, and as described in the rider. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the Maximum Benefits, Coinsurance and other limitations shown for this Rider [and the Policy Deductible shown] in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Skilled Nursing Care		
Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Limited to [30 days] per Insured Person, per [Calendar Year]		
Maximum Benefit per Insured Person, per day [\$250]		
Home Health Care		
Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Limited to [80 visits] per Insured Person, per [Calendar Year]		
Not to exceed a [\$50] Maximum Benefit per Insured Person, per day		
Private Duty Nursing		
Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Limited to [40 eight-hour shifts] per Insured Person, per [Calendar Year]		
Not to exceed a [\$50] Maximum Benefit per Insured Person, per shift		
Hospice Care		
Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Not to exceed a [\$5,000] Maximum Benefit per Insured Person, per lifetime		

Legend Prescription Drug Expense Rider (Form Number 25985 (10/05)-IR) AR - We will pay a benefit if an Insured Person incurs Covered Expenses for Sickness or Injury. This benefit is the amount equal to the actual charge based on Participating Pharmacy prices for a Covered Expense, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

Deductible, per Calendar Year, per Insured Person ☐ \$50 ☐ \$100

Participating Pharmacy

(Not to exceed a 30 day supply)

Generic Drugs

We pay [100%] less the [\$15] Copayment

Formulary Drugs

We pay [50%], You pay the remainder

Non-Formulary Drugs

We pay [25%], You pay the remainder

Non-Participating Pharmacy

(Not to exceed a 30 day supply)

Generic Drugs

We pay [75%] less the [\$15] Copayment

Formulary Drugs

We pay [25%], You pay the remainder

Non-Formulary Drugs

We pay [0%], You pay the remainder

Mail Service Legend Prescription Drugs

(Not to exceed a 90 day supply through Our designated mail service program)

Generic Drugs

We pay [100%] less the [\$30] Copayment

Formulary Drugs

We pay [50%], You pay the remainder

Non-Formulary Drugs

We pay [25%], You pay the remainder

Benefit Maximum

Per Insured Person

[\$1,500] per Calendar Year

[PREVENTIVE PLUS] Benefit Rider (Form Number 26028 (10/05)-IR) – Benefits under the Rider are provided for [Medically Necessary] [non-Covered Expenses] for [Physician office visits, except for visits related to Mental or Nervous Disorders or fertility treatment;] [Allergy injections;] [Outpatient Diagnostic expenses not otherwise considered a Covered Expense under the Policy or any attached Riders;] [Emergency Room services not otherwise considered a Covered Expense under the Policy or any attached Riders; and] [Spinal manipulations]. [Routine preventive health care services, including but not limited to routine physical exams and related laboratory and x-rays services and immunizations, not otherwise paid under the Policy; and] [Acupuncture] will also be considered under the Rider.

All Benefits under the Rider are subject to subject to [Usual and Customary Charges][the Maximum Allowable Charge (MAC)], based on the Annual [PREVENTIVE PLUS] Benefit Amount selected, subject to a Quarterly Benefit Accumulation Amount.

**ANNUAL [PREVENTIVE PLUS] BENEFIT
AMOUNT:**

☐ \$250

☐ \$500

☐ \$1,000

☐ \$2,000

**QUARTERLY BENEFIT ACCUMULATION
AMOUNT:**

(per quarterly Rider anniversary for You and
Your Covered Dependents, if any)

[\$62.50]

[\$125.00]

[\$250.00]

[\$500.00]

Benefits under the Rider can accumulate if unused; however, there are limits to the amount that can accumulate. If there is more than one Insured Person covered under the Rider, there are limits to the maximum amount

available to each Insured Person. Any Pre-Existing Condition limitations, conditions excluded by Waiver or Benefits paid under the Policy or any attached Riders, will not be considered under this Rider.

Benefits will be paid from the [PREVENTIVE PLUS] Benefit Amount on the date the services are rendered. Benefits accumulated subsequent to the date the services are rendered will not be used to pay benefits on services rendered before the accumulation date. In order for benefits to be considered under the Rider, services must be rendered during the time period for which premium has been paid for the Rider.

Emergency Services Benefit Rider - (Form Number 26032 (10/05)-IR or 26032 PPO (10/05)-IR)- Covered Expenses incurred while the Rider is in force for Emergency Treatment of a Sickness or Injury not resulting in Hospital Confinement. The Benefits provided by this Rider will not duplicate the Benefits provided under the Policy and any other rider and are subject to the [[Policy Deductible] shown in the POLICY SCHEDULE] [and the [Copayment,][and Coinsurance][and Maximum Benefit] shown for this Rider in the POLICY SCHEDULE.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance [Not to exceed a [\$1,000][\$2,000] Maximum Benefit per Insured Person, per visit]	[<input type="checkbox"/> 70%][<input type="checkbox"/> 80%][<input type="checkbox"/> 90%]	[<input type="checkbox"/> 50%][<input type="checkbox"/> 60%][<input type="checkbox"/> 70%]
[Physician's Office or Urgent Care Center Copayment, per visit [<input type="checkbox"/> \$100] [<input type="checkbox"/> \$250] [<input type="checkbox"/> \$500] [<input type="checkbox"/> \$1,000]]		
[Hospital Emergency Room Copayment, per visit [<input type="checkbox"/> \$100] [<input type="checkbox"/> \$250] [<input type="checkbox"/> \$500] [<input type="checkbox"/> \$1,000]]		

Physician's Office Visit Benefit Rider[*] (Form Number 25886-IP) - We will pay Covered Expenses incurred by an Insured Person, while this Rider is in force, for Medically Necessary visits to the Physician's office or clinic and for related care services provided by the Physician as a part of such visit. Benefits payable under this Rider are not subject to the Policy Deductible.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Copayment, per Insured Person, per visit	[\$30]	[\$30]
Daily Maximum Benefit, per Insured, Person per visit	[\$125]	[\$100]

Maximum Number of visits per calendar quarter
For You and Your Covered Dependent Spouse
[☐ 1] [☐ 2] visits each

Maximum Number of visits per calendar quarter
For Your Covered Dependent Child(ren)
[☐ 2] [☐ 4] visits each

[*The **Sickness Exclusion**, as shown in the EXCLUSIONS AND LIMITATIONS section of this Policy, does not apply to this Rider.]

- 8. RIGHT TO RETURN POLICY** - It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return the Policy to Us at Our administrative office in North Richland Hills, Texas, within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Policy Date, refund all premiums paid and treat the Policy as if it were never issued.

9. **PREMIUMS** - We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Policyholder written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.

Initial Premium for Policy	_____
[Policy Fee	_____]
Rider Premium	_____
Total Initial Premium due with Application	_____